Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3667-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TWIN CITY FIRE INSURANCE CO Box #: 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "My Insurance carrier paid for other medications but would not pay for pain med. Prescribed. Enclosed are the bills that I have paid. Also they still owe Dr. Rauns office for Jan. & Feb. of 2009."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Total Amount Sought $4,260.59

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary as stated on the Table of Disputed Services: "Denied per Peer Review Please see attached. Do not show having received billing prior to dispute. "

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
08/27/08 – 04/09/09	No EOBs submitted for the disputed dates of service	Out-of-Pocket Expenses for Prescriptions	$4,260.59	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of Rule §133.270 and §134.503.

2. According to Division Rule §133.270 the injured employee may request reimbursement from the insurance carrier when the injured employee has paid for health care provided for a compensable injury. The injured employee's request for reimbursement shall be legible and shall include documentation or evidence, such as itemized receipts, of the amount the injured employee paid the health care provider or pharmacy. In accordance with Division Rule §133.307(c)(3)(D) a copy of the carrier's denial of reimbursement relevant to the dispute, or, if no denial was received, convincing evidence of the employee's attempt to obtain reimbursement from the carrier. The dispute package contained no evidence to support the injured employee's attempt to obtain reimbursement from the carrier.

3. In accordance with 28 Texas Admin Code Section §133.307(c)(1)(A) a requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division received the dispute on April 13, 2010, the submitted dates of service, 08/27/08 – 04/09/09 for out-of-pocket expenses for prescription medications, are outside the one-year timeframe and not eligible for review.

4. Pursuant the Division Rule §133.307(e)(3)(E) the Division concludes that this dispute was not submitted timely. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.305, §133.307, and §134.503

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

Authorized Signature	Auditor III Medical Fee Dispute Resolution	July 6, 2010 Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.